UNITED STATES DEPARTMENT OF AGRICULTURE
FARM SECURITY ADMINISTRATION

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SUMMARY OF THE MEDICAL CARE PROGRAM OF FARM SECURITY ADMINISTRATION

A family that is unable to secure needed medical, dental and hospital care cannot make desired progress toward rehabilitation and economic independence. Moreover, a family in good health is a better credit risk than a family in bad health. It has not been practicable or possible for Farm Security Administration to lend or to give all of its borrowers and grant clients the full amount of money needed to pay for all needed medical services, if such services were to be paid for according to regular medical fee schedules. Therefore, it has been necessary to devise various medical service plans designed to fill the need of particular areas and of certain types of borrowers or groups of borrowers.

In January, 1936, Dr. Robert Oleson, a Medical Officer of the United States Public Health Service, was assigned by the Treasury to serve as Medical Director of the Resettlement Administration. He was succeeded on June 26, 1936, by Dr. R. C. Williams, who was attached directly to the Office of the Administrator. Later his title became "Chief Medical Officer". Dr. Williams has continued to supervise the Medical Program of Farm Security Administration. He is assisted at present by a Washington staff composed of one Medical Officer, one Dental Officer, one Sanitary Engineer, one Statistician, one Health Services Specialist, and one Supervisory Nurse, and a field staff of five Area Medical Officers, eleven Health Services Specialists, and seven Sanitary Engineers, who work in close cooperation with the State Cooperative Specialists, the District Supervisors, and other FSA personnel.

Administrative Organization

The Chief Medical Officer is administratively responsible to the Administrator; the Supervisory Nurse, the Medical Officer attached to the Washington Office, and the Medical Officers assigned to the regional offices are administratively and technically responsible to the Chief Medical Officer; the Health Specialists are under the technical guidance of the Chief Medical Officer and are administratively responsible to the regional director in whose region they are working for the supervision of the medical care program. The functions of the Chief Medical Officer and his staff include necessary negotiations and liaison between the Farm Security Administration and state medical, dental, hospital, nursing and pharmaceutical associations in developing and recommending medical care plans for Farm Security Administration borrower and client families; necessary conferences with community managers and groups of Farm Security Administration borrowers regarding their

health requirements; and responsibility for the technical guidance in the organization, development and supervision of various Farm Security Administration medical care programs. It is the responsibility of the Chief Medical Officer and his staff, in cooperation with the Administrator's staff, division directors, regional directors and other agencies, to formulate, develop and recommend a broad program involving (1) medical care and environmental sanitation for RR clients, tenant purchase borrowers, and indigent migratory agricultural workers; (2) medical care, community nursing, and environmental sanitation for families of occupants on resettlement type project; (3) physical rehabilitation of handicapped clients, occupants, borrowers, or their families; (4) physical examination of families of new clients, occupants, and borrowers; (5) physical inventory of as many families of occupants on resettlement type projects, RR clients and TP borrowers as may be practicable, and (6) preparation of health information material. (FSA Instruction 012.14).

Process of Developing Medical Care Programs

The first step in developing medical care programs is to acquaint State Medical Associations with the needs of FSA borrowers and to enlist their cooperation and aid in meeting these needs. This is effected through direct approach by the Chief Medical Officer or member of his staff, or by other Farm Security Administration employees under the direction of the Chief Medical Officer. After satisfactory working arrangements have been agreed upon with the State Medical Association, details of operation such as organization, participating physicians, types of service, membership eligibility, cost per family, and method of payment of fees are worked out with local medical societies. During 1939 definite agreements of cooperation in conducting health programs were in effect with the State Medical Associations of 32 states. Limited or informal agreements were in effect in 6 states. Working agreements relative to the medical care of RR clients have not yet been reached with the State Medical Associations of Massachusetts, Connecticut, Rhode Island, Delaware, Michigan, Minnesota, North Dakota, California, Nevada, and Idaho. An agreement concerning migratory agricultural workers is in effect in the State of California.

Types of Low-Income Farm Families for whom Medical Care is Provided

The medical care program of Farm Security Administration extends to all types of FSA borrowers and clients, and, to a limited extent, its benefits also innure to other low-income farmers.

Resettlement Project Borrowers: Medical care programs are now being conducted on approximately 46 Resettlement Projects, 26 of which are for Resettlement Project borrowers only, and 19 of which are for Resettlement Project and Rural Rehabilitation borrowers combined. Project programs organized in 1937 and 1938 were designed to meet the needs of project families only, and in most areas where the projects were located, the development of medical care plans for rehabilitation families had not yet commenced. As plans for rehabilitation borrowers developed, the co-existence of two medical plans in one county has been confusing to physicians and has not always been satisfactory from an administrative viewpoint for the Farm Security Admin-

istration. A tendency to combine Project and Rehabilitation medical care programs is now asserting itself. The great majority of the programs now pending in the projects will be combined programs, and plans have been formulated for merging a number of coexistent programs now in operation in the same areas.

Tenant Purchase Borrowers: It has been the policy for all families receiving Tenant Purchase loans to receive medical examinations. Such medical examination was not required as a condition for securing a loan except when the county committee so desired in order to remove any doubts as to the health of the prospective borrower or any member of his family. (FSA Instruction 616.1). However, the procedure regarding medical examinations for TP borrowers is in process of revision. A change in FSA Instruction 616.1 III is pending which has not yet received official approval. The contemplated revision provides that all families receiving TP loans must receive medical examinations before being certified by county committees as eligible for such loans. However, as indicated in Paragraph F of FSA Instruction 611.6 (Criteria for Selection of Applicants), it is only incurable physical disabilities likely to interfere with successful farm and home management operations and with the repayment of the loan that render a family ineligible. It is assumed that the families themselves will benefit from the examinations by discovering conditions requiring correction or preventive treatment. Physicians making examinations for TP borrowers are employed by FSA on a WAE basis, or they may be employed under a contract for personal services and be paid by the applicants from their personal assets or from the service fee included in the loan. If the loan is not approved, the fee may be paid by FSA from administrative funds. TP Procedure requires that all such physical examinations should be made by doctors selected by the FSA, with the advice of the state medical association or county medical society. The services of the Chief Medical Officer or his staff are utilized in arranging for these examinations only in an advisory capacity, if and when needed. Tenant Purchase borrowers residing in counties or areas where FSA cooperative medical programs are being conducted are encouraged to participate in such cooperative programs.

Rural Rehabilitation Borrowers and Grant Clients: Medical services for rehabilitation borrowers are provided through two general methods. One method is through the use of the Farm and Home Plan on which is based the standard loan made to a farm family. Each Farm and Home Plan sets up an amount of money estimated to cover ordinary medical attention for the family. If necessary, the standard loan includes enough money to cover this estimated amount. Under this arrangement the borrower chooses his own physician and pays his own medical bills. Should the anticipated income of a family to which a standard loan is advanced not be sufficient to provide for medical services or to repay a loan made for such services, rather than imperil the amount set up as necessary for subsistence and operating needs of the family, a direct grant, supplementing the loan, is made to provide for such medical service. However, the making of grants for such service is not encouraged except as a last resort in such cases where medical care is absolutely essential to the successful rehabilitation of the family and cannot be provided from farm income or through welfare agencies. Grant Procedure, FSA Instruction 741.1, also provides that grant for medical services may be made to emergency borrowers or clients. The free use of grants for medical services, however, either to borrowers or grant clients, is

not desirable. Physicians, generally, are unfavorable to a plan whereby the Government designates a certain sum for medical fees and subsidizes the amount of money so designated. It is difficult, too, to draw a line as to where one low-income family should pay for medical service by means of a grant, which need not be repaid, another low-income family should pay for such service out of a very limited farm income, and yet another family pay for such service out of a loan made for that purpose, which loan must be repaid. The following is quoted from a memorandum from Dr. Williams to Dr. Mitchell dated September 26, 1939, "It has been found that it is difficult to develop medical care programs in counties where grants for medical care have been used." This same attitude is expressed in letter dated October 30, 1939, from C. M. Evans, Regional Director of Region VIII, as follows: ". . . We hope to be able to continue to reduce the amount of grants for emergency medical attention to a minimum in order that the medical care programs can be placed in those counties with less objection on the part of physicians and surgeons."

Disease and sickness and the cost thereof for an individual family are not always predictable, and an amount of money estimated in a Farm and Home Plan at the beginning of the year to take care of such cost may not be sufficient to provide for all the medical care which a family may need. A second and more satisfactory method for planning for needed medical care is through the facilities offered by a group association organized along cooperative lines for such purpose. Farm Security Administration makes loans available to individuals to enable them to participate in such medical care associations. These are made only to standard rural rehabilitation borrowers who are operating under an approved Farm and Home plan.

Organization of Medical Care Programs

Before inaugurating a medical care program in a state, the Medical Staff first effects a satisfactory working agreement with the State Medical Association. Then, in areas, where the need seems greatest, details of medical care plans are worked out by the local medical societies and Farm Security Administration representatives.

In general two forms of organization are utilized in setting up medical service plans for rehabilitation borrowers. Simple unincorporated associations, organized according to the laws of the state in which they operate, have been organized in many areas with boards of directors composed of FSA borrowers only or of both FSA borrowers and representatives of the Farm Security Administration. To an approximately equal extent, however, trusteeships rather than associations have been set up. In such instances there is no organization of borrowers except for the appointment or election of advisory committees of borrowers in certain states or regions. The borrowers simply execute participation agreements under which they deposit funds with a trustee authorizing him to disburse their funds in accordance with the program approved by the local medical society. The unincorporated association or organization form is utilized primarily in Regions VI, VII, VIII, X and XI.

In Regions I, III, IV, V, and XII the form of organization is usually a Trusteeship. There is some overlapping, however; there being instances of both types or organization in virtually every Region. Even where unincorporated associations have been organized, they are seldom active working organizations because of distance and other factors. In some areas meetings of the boards of directors are held occasionally, but membership meetings are rare. Even where there are medical care associations, funds are often held by a neutral trustee rather than by a treasurer selected from the participants.

In general, trustees (or treasurers) are neutral persons who are not borrowers, FSA employees or physicians. There has been a considerable tendency in the past to have FSA employees serve as trustees of the medical care funds, but the general policy at present in almost every Region is to select an outside person, such as a bank cashier, even though most of the records of the association may still be kept in the FSA office. There is also a tendency not to utilize physicians as trustees because of the possible conflicting interests of the physician placed in such a position. The trustee is generally allowed approximately 5% of the pooled funds for administrative expense in conducting the affairs of the medical group or association

Forms for by-laws of unincorporated health associations have been made available to all Regions by the Solicitor's Office. By-laws adopted by the respective health associations may differ in minor points but follow the general form approved by the Solicitor's Office. The application of these by-laws, however, is still limited, as associations of varying forms had already been organized prior to the distribution of the approved form for by-laws. However the form of organization of such pre-existing associations had been approved by the regional attorney and the Solicitor's Office.

Types of Plans for Payment of Participation Fees and Distribution of Funds

Common Fund Plan: The type of plan in general use for payment of participation fees and distribution of funds is that in which a common or pooled fund is created by contributions of the individual borrowers. It is much the same as an insurance fund for there is no refund to the family requiring no care, unless, in exceptional circumstances, there should be a distribution of surplus funds to all participating families at the end of the fiscal period. Ordinarily, the pooled fund for one year's operation of the plan is set up in advance through the mechanism of making loans to the clients for the full annual amount of their participation dues. After the deduction of administrative expenses, which in general never exceed 5 percent, the fund may be divided into separate allocations for general practitioner care, hospitalization, drugs, dental care, or other services which may be included in the medical plan. The funds for a certain purpose, such as physicians' care, are then divided into equal monthly allotments. Physicians' bills are submitted monthly and are paid from the monthly allotment. Bills are paid in full if funds are sufficient, and, if the monthly allotment proves insufficient, it is distributed on a pro rata

basis. When a surplus occurs in a given month, it is ordinarily held until the end of the year when any surplus funds are applied against unpaid balances still owing on physicians' bills. In such a plan hospitalization bills are not always paid on a similar pro rata basis. In a number of plans hospital bills are preferred charges which are paid first and in full from the gross monthly allotment, after which payment of physicians' bills is made. In some plans drug bills and emergency dental care bills are also preferred charges.

Capitation Fee Plan: There is a growing tendency to set up plans based on a capitation fee. In such a plan each physician receives a definite amount from the pooled fund each month based on the number of families who have selected him. If ten families have selected a certain physician, for example, he receives each month one-twelfth of the combined funds deposited by these ten families. Plans based on a capitation fee of this type offer less inducement for physicians to attempt to secure more than their share of the available funds. Several programs of this type have been organized in Alabama, Georgia, and South Carolina, and others are contemplated in Louisiana and Mississippi.

Individual Participation Plan: In Region III another type of plan, which might be termed the individual participation plan, was prevalent until recently, when, with the approval of the various State Medical Associations, a gradual conversion to the common fund type of plan is now being carried out. In the individual participation type a loan is made to the individual family and is kept as a separate entity to be drawn upon to pay bills incurred by that family. In this plan the balance remaining at the end of the year is refunded to the family. Another provision of this plan is that the family physician agrees to continue to serve the family for the balance of the year after the family's funds are exhausted.

Individual Contract Plan: Another type of plan which has been used in some instances but is gradually disappearing is that of the individual contract between families and their physicians. In this plan the physicians selected by the families receive a certain amount each month regardless of the amount of service provided. A few of these plans are still in effect in Arkansas, Louisiana, and Mississippi.

The amount of fee paid by each participant family in any of the above plans varies from about $15 to about $30 a year depending on the benefits extended, the size of the average farm income in the locality, and the size of the family. Payments of bills rendered by physicians average approximately 65 percent of the total bills presented, which many physicians report is a higher percentage of payment than would ordinarily be received from their regular practice in the same area. A serious financial obstacle in the progress of the medical program is presented through those cases in which chronic defects and diseases existed prior to the acceptance of the individual as a Farm Security Administration borrower or client. Attempt is being made to arrive at some satisfactory solution of this problem.

Status of the Medical Care Programs for RR Borrowers as of December 31, 1939. Reference should be made to the Chief Medical Officer's Progress Report for 1939 for detailed information as to the agreements in effect with State Medical Associations, number and names of counties in which medical care programs were functioning, number of family and individual participants in each program, average amount of membership fee per family, and types of service offered by each medical unit. The following comments are based on excerpts from the Progress Report.

Region I: Development of the program has been delayed because of the more urgent demand for assistance in areas with heavier case loads and more acute problems. The comparatively small case load in this Region detracts seriously from "bargaining power" in negotiating with the medical profession. Much of Region I is industrialized, and the physicians practising in the large towns and cities find it difficult to visualize rural medical care problems.

Region II: The program has been slow to develop in this Region. Physicians have been reluctant to initiate medical care programs until they have had further opportunity to observe the operation of medical plans in other states. An important factor in the lack of progress has been the change in regional medical staff personnel and the lack of a full-time health specialist.

Region III: Progress during 1939 was quite satisfactory and far reaching plans have been made for expansion during 1940.

Region IV: Programs were confined to North Carolina, Tennessee and Virginia, but several medical societies in Kentucky and West Virginia had approved plans for 1940.

Region V: The program has expanded rapidly. A major factor for this is the action taken by the regional director in 1938 in making mandatory the inclusion of funds for medical care in all RR loans, thus making it possible to build programs through which the money would be most advantageously spent. More progress was made in the State of Georgia in this Region during 1939 than in any other State.

Region VI: On May 9, 1939, the Mississippi State Medical Association went on record as not approving the FSA program, thus rescinding an informal agreement which had been in effect since 1937. However, at the annual meeting of the association held in May, 1940, the Speaker of the House of Delegates of the State Medical Association made a ruling which in effect left the whole question of cooperation in the hands of individual physicians and county medical societies. This ruling has been considered the necessary authority to permit continuation and expansion of the medical care program in that State. That the action of the House of Delegates in 1939 did not meet with the approval of the majority of physicians in Mississippi is witnessed by the fact that medical service plans were terminated in only two counties in the State during the past fiscal year. As of June 1, 1940, there were three more programs in operation than there were in June 1939.

Region VII: Programs formerly operating in North Dakota and South Dakota are no longer functioning. The chief difficulty in the operation of these programs seemed to be an excessive proration of charges for service. However, at the recent meeting of the House of Delegates of the State Medical Association of North Dakota a resolution was passed permitting the local medical societies of that State to negotiate with the FSA with the understanding that all developments must be approved by the Executive Committee of the State Medical Association. At the end of the fiscal year negotiations were being carried on with the McHenry and Pierce County Medical Societies. In South Dakota 11 counties centering around Pierre have indicated a willingness to cooperate further with the FSA toward developing programs in the future.

Region VIII: The program is progressing satisfactorily in both States in this Region.

Region IX: One medical program in San Juan County, Utah, and one dental program in Weber County, Utah were the only programs functioning during 1939 in this Region. Both programs include FSA borrowers and clients and non-FSA families as participants. An agreement is in effect in California concerning agricultural migratory laborers, but no programs have been approved for rural rehabilitation borrowers either in California or Nevada.

Region X: The appointment of a Health Services Specialist in this Region during 1939 greatly accelerated the organization of medical programs. Only nine county programs were in effect during 1939.

Region XI: An informal agreement was in effect in Teton County, Idaho, designed to care for the needs of FSA borrowers and clients and non-FSA families. No other programs were in effect in this Region during 1939.

Region XII: The program has expanded rapidly in this Region. This may be attributed in large part to the assistance of the Health Specialist assigned primarily to this Region.

Special Programs

Sanitation Program: The first essential for a successful medical care service is that the family be provided with proper water supply, facilities for the proper disposal of human wastes, and means of control of insect pests that transmit disease. A sanitation program to aid in the correction and protection of family health began operation in May, 1936, and is now being conducted under the supervision of Mr. D. W. Evans, Sanitary Engineer, attached to the Medical Staff. The first operations of this program were concerned with the design, construction, and operation of facilities for water supply, sewage and waste disposal, drainage and mosquito control measures for individual farm units and community centers on Resettlement Projects, and sanitation facilities of recreation areas on the Land Utilization Projects, such as water supply, sewage disposal, bathing facilities, and mosquito control. Supervision of these projects continues, and in the Progress Report for 1939, Mr. Evans recommends that someone on these projects be assigned the definite responsibility of maintenance. Under the present leasing arrangement, tenants have not assumed this responsibility, and the project officials in

a number of cases have not been able to cope with the problem. During the past year Sanitary Engineers have also been assigned to aid the supervisors in planning repairs, construction and inspection of farms and farm buildings in connection with the Tenant Purchase program. The Sanitary Engineer also supervises the sanitation conditions of Migratory Labor Camps which are in different stages of design, construction or operation. He further supervises an Environmental Sanitation Program, which, after successful pioneering experimental efforts, was inaugurated late in 1939 on a nation-wide basis for the benefit of rural rehabilitation borrowers and grant clients. A total of $1,800,000 in grant money was allocated to the Regions for this purpose. (See "Summary of Farm Security Administration Environmental Sanitation Program", dated May 16, 1940.)

Physical Examination Program: During April, 1939, thorough medical and dental examinations, including a study of the mental age of adults, were performed on 100 non-commercial families in Laurence and Oglethorpe Counties, Georgia. This survey revealed that a number of persons were found to be in urgent need of immediate medical treatment, and that there was widespread nutritional deficiency among the families and a significant amount of physical disability and chronic disease. It was thought that examinations of typical clients would prove invaluable in giving an exact picture of health conditions among FSA borrowers on which to base plans for further development of the general health program. Departmental authority for conducting physical examinations of rehabilitation borrower families in at least one representative county in as many states as practicable was contained in memorandum dated September 15, 1939, addressed to the Administrator of Farm Security Administration, signed by Harry L. Brown, Acting Secretary. The following is quoted from this memorandum, "It is understood (1) that these examinations will be on an experimental basis for the purpose of determining health conditions among certain Farm Security Administration families in selected counties and ascertaining the improvements in their health that can be effected by proper treatment; (2) that these examinations are intended to aid in ascertaining the relationship between the health of Farm Security Administration clients and their families and their ability to repay the loans made to them by the Government; and (3) that it is not the intention of the Farm Security Administration to enter upon a wide-scale program of making direct grants for corrective treatments." The sum of $50,000 was allocated for carrying out this program. Special provision and facilities for conducting the examinations are arranged for by the Medical Staff. The following table shows the status of this program as of June 10, 1940.

Table I. Status of Physical Examination Program of Farm Security Administration as of June 10, 1940.

State	County	No. of families examined	No. of persons examined
Arkansas	Pope	175	820
Florida	Levy	183	668
Georgia	Worth	137	840
Louisiana	Franklin Parish	229	1,102
Mississippi	Carroll	46	170
Mississippi	Leflore-Humphrey	82	338
North Carolina	Avery	65	250
Ohio	Champaign	113	442
South Carolina	Kershaw	179	1,030

Examinations Scheduled to be Held in Near Future

State	County
Colorado (Reg. X)	Phillips
Indiana	Montgomery
Maine	Aroostook
Maryland	St. Marys
Missouri	Calloway
Nebraska	Howard
Tennessee	(To be selected)
Texas (Reg. VIII)	Runnells
Virginia	Spotsylvania

Agricultural Workers Health and Medical Association: A more definitely relief type of medical program is in operation among migratory agricultural workers in California and Arizona. This work is being carried on by the Agricultural Workers Health and Medical Association which was organized in February, 1938, by the FSA in cooperation with the California Medical Association, the State Department of Health, and the State Relief Administration. This organization first began service through 6 different offices in California in May, 1938, and the Association's report for August of that year mentions some service in Arizona. In October, 1938, an arrangement was made with the State Board of Health of Arizona and the Medical Association of Maricop County for the definite extension of the Association's service into that State. At the end of 1939 the service had extended to 13 district offices in California and 7 district offices in Arizona. These offices were opened at points where concentration of migratory workers seemed to indicate the most need for them. In addition to the district offices, 9 clinics in California and 6 in Arizona have been opened for

treatment of clients, supplementing the services available through the district offices. Eighteen counties in California and 3 in Arizona are now included in the area serviced by this Association. The service is primarily for workers who have migrated into California and Arizona and, not having established residence, are not entitled to state relief, but the Association is also continuing to render service to some of its members following their establishment of residence. There is no membership fee, but provision is made for repayment of costs of service if the members are able to make such repayment. Services provided are physicians' care, nursing, hospitalization, drugs, medical supplies, special diets and limited dental service. The Association also cooperates with the State Health Departments in each State in promoting a program of immunization and preventative measures for controlling infectious diseases. During 1939 lunches for children attending primary and nursery schools in camps maintained by FSA were also added to the functions of the Association, and as of December 31, 1939, $3,883.95 had been spent for this service. Medical services are rendered by physicians who have indicated their willingness to cooperate in this program. Charges for such services are submitted to the Association by the person rendering the service and after careful review by qualified professional advisers, are paid monthly from grant funds provided by Farm Security Administration. As of June 15, 1940, Farm Security Administration had advanced $2,107,000 in grant money to this Association. The number of cases of illness treated by the Association during 1939 is not available. However, figures for the period March 1, 1939 to February 29, 1940, indicate that during that period 31,183 cases of illness received physicians' care, of which 6,529 or 20.9 percent were hospitalized. These figures do not include clinic services. Records indicate that during December, 1939, 8,803 visits were made to the 15 clinics. The work of the Association has been so successful that similar programs are planned for the migratory labor camps in the States of Washington, Oregon, Idaho, Texas and Florida.

Concluding Comments

The Washington records of Community and Cooperative Services Section indicate that as of December 31, 1939, loans had been made to participants in 198 medical cooperatives or associations operating in 411 counties, with a total membership of 33,712 family participants. A total of $542,548.23 had been advanced in loans for this purpose. The average amount per group application was $2,740.14, and the average loan per member was $16.09. The Community and Cooperative Services Section advises, however, that there are some medical cooperatives or associations in operation for which data have not been received in the Washington Office.

The Progress Report of the Chief Medical Officer for 1939 indicates that as of December 31, 1939, medical care programs were in effect for rural rehabilitation borrowers in 478 counties, with 65,029 families participating, or approximately 338,151 individuals. These figures include some low-income farmers who are not FSA borrowers or clients. The number of counties in which such programs were in effect at the end of June 30, 1940, had increased to 633 in 31 states. Some medical care programs have been set up by FSA field personnel, the records of which have not yet reached the Office of the Chief Medical Officer.

Information concerning the activities and status of medical care groups is furnished to the regional office and to the Washington Office through the Simplified Accounting System for Medical Care Groups provided for in FSA Instruction 357.1, Exhibit A. Information concerning the amount of grants made for medical purposes, by counties, should be available in each regional office, following letter dated December 5, 1939, from Dr. Mitchell to all regional directors, instructing them to keep such a record in the regional office and at regular intervals of two or three months to provide the Regional Health Specialist and the Area Medical Officer with a summary thereof. This instruction followed a request from Dr. Williams for such information in his memorandum to Dr. Mitchell, dated September 26, 1939. Detailed information about the development, history, functions, and present status of operation of the various medical care programs is available through the Monthly Reports made by the Chief Medical Officer, through his Progress Report for 1939, through his regular fiscal year reports, or through other records in his office. However, information and records are not available in Washington as to the number of loans or grants made for medical purposes, or as to the amount of money advanced for such purposes.